Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service 07/30/01, 09/05/01 and 09/19/01?
   b. The request was received on 03/06/02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC-60 and Letter Requesting Dispute Resolution
   b. Provider marked exhibits 1-19
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. TWCC-60 and Response to a Request for Dispute Resolution
   b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 05/22/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 05/22/02. The response from the insurance carrier was received in the Division on 06/05/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The provider has not received proper reimbursement for services associated with an epidural steroid injection.

2. Respondent: The carrier has reimbursed the provider properly.

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only dates of service eligible for review are 07/30/01, 09/05/01 and 09/19/01.

2. The carrier's EOBs have the denials, "**F-N** – THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING 'ACCURATE CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT'. THE SERVICES PREFORMED ARE NOT REIMBURSABLE AS BILLED", "**F** – REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE", "**G** – REIMBURSEMENT FOR THIS PROCEDURE IS INCLUDED IN THE BASIC ALLOWANCE OF ANOTHER PROCEDURE" and "**F-DOP** – REIMBURSEMENT IS NOT ALLOWED WITHOUT THE REQUIRED DOCUMENTATION OF PROCEDURE AS DEFINED IN THE 04/06/96 TWCC MEDICAL FEE GUIDELINE, PAGE 1".

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MAR$	REFERENCE	RATIONALE:
7/30/01 9/5/01 9/19/01	76499-27-22	$350.00 $350.00 $350.00	$88.00 $88.00 $0.00	F-N, F F-N, F F-N	DOP	MFG, GI (I)(A&B) & (III), CPT & modifier descriptors, TWCC Advisory 97-01 Texas Workers' Compensation Commission Act & Rules, Sec. 413.011(d)	The CPT descriptor states, "Unlisted diagnostic radiologic procedure." The medical documentation indicates that the provider is billing for fluoroscopic guidance (fluoroscopy). The MFG GI (I)(A) states, "…(TWCC) has incorporated usage of the …(AMA's) 1995 …(CPT) codes". The MFG has CPT code 76000 which has the descriptor "Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg. cardiac fluoroscopy)". The CPT code 76000 is sufficiently descriptive of the procedure performed and the MAR value of 76000-27 is $88.00. Although the provider did not bill CPT code 76000, the carrier has provided proper reimbursement for DOS 07/30/01 & 09/05/01. The provider is entitled to reimbursement of **$88.00** for DOS 09/19/01.
07/30/01 09/05/01 09/19/01	76499-27	$300.00 $300.00 $300.00	$0.00 $0.00 $0.00	G G G	DOP	MFG, GI (II)(A&B) & (III), CPT & modifier descriptors, TWCC Advisory 97-01	The TWCC Advisory 97-01 states, "…When videofluoroscopy or fluoroscopy is performed with a myelogram or discogram, **such procedures** (emphasis added) are considered part of the service and should not be billed separately. The procedure in dispute is an epiduragram and is a procedure that should not be reimbursed separately. Therefore, no reimbursement is recommended.

07/30/01 09/05/01 09/19/01 09/19/01 07/30/01 09/05/01 09/19/01	A4649 A4209	$15.00 $15.00 $15.00 $25.00 $10.00 $10.00 $10.00	$0.00 $0.00 $0.00 $0.00 $0.00 $0.00 $0.00	G G G G G G G	DOP	MFG, SGR (V)(B)(1)	The SGR (V) discusses the CPT codes that are reimbursable when surgical procedures are performed in a doctor's office. The referenced SGR states, "Sterile trays (which includes all supplies, gloves, utensils, needles, suture material, etc., needed to perform the procedure). These shall be billed using 99070-ST." These codes should not be billed or reimbursed separately. Therefore, no reimbursement is recommended.
09/05/01	99499-RR	$50.00	$0.00	F-DOP	DOP	MFG, General Instructions (III), SGR (V)(B)(1-3)	The medical documentation contained in the dispute packet provides sufficient documentation of the service provided to justify reimbursement. Therefore, reimbursement of **$50.00** is recommended.
Totals		$2100.00	$176.00				The Requestor is entitled to additional reimbursement of $138.00.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $138.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 10th day of September 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division